TRICARE EUROPE PRIME ENROLLMENT APPLICATION

SPONSOR INFORMATION

CAN BE COMPLETED BY ANY ADULT BENEFICIARY. SEE REVERSE FOR DIRECTIONS. PLEASE PRINT CLEARLY.

1. Sponsor Name (last, first, middle initial)	2. Sponsor Social Security Number	3. Sex	4. DEROS / PRD	5. Date of Birth (dd/mmm/yyyy)	6. Rank	7. Telephone Numbers
						Duty
						Home

8. Duty Address (Unit, Office Symbol, Station, APO/FPO)	9. Mailing Address (Box Number, APO/FPO, Zip)	10. Preferred Primary Care Site

11. Branch of Service (circle one)				12. Sponsor Status (circle one)				13. Sponsor Medical Conditions
Army	Air Force	Navy	Marines	Active Duty	Retired	DoD Civilian	Reserve	
NOAA	PHS	USCG	Other	Deceased	Other (Specify)			

FAMILY MEMBER INFORMATION

LIST ALL FAMILY MEMBERS WHO ACCOMPANIED THE SPONSOR TO EUROPE AND ARE APPLYING FOR ENROLLMENT. PLEASE PRINT CLEARLY

14. Family Member Name (last, first, middle initial)	15. Family Member Social Security Number	16. Sex	17. Date of Birth (dd/mmm/yyyy)	18. Preferred Primary Care Site	19. Family Member Medical Conditions

20. Enrollment Authorization		21. Signature
	Yes, enroll my family in the TRICARE Europe Prime Program.	Signing this document affirms that you understand the Privacy Act Statement on the reverse side and that you request the action indicated.
	No, do not enroll my family in TRICARE Europe Prime. We understand that this decision will result in our payment of deductibles and cost-shares for care received from host-nation sources.	Signature Date

WHITE COPY 1 / GOVT COPY BLUE COPY 2 / ENROLLEE COPY PLEASE RETURN THIS COMPLETED APPLICATION TO YOUR TRICARE SERVICE CENTER

INSTRUCTIONS

1. SPONSOR NAME. Last name, first name, middle initial.
2. SPONSOR SOCIAL SECURITY NUMBER. This is the SSN of the active duty member or the retired member.
3. SEX. M or F.
4. DEROS/PRD. Date Expected Return From Overseas (Army/Air Force) or Projected Rotation Date (Navy). Please list by dd/mmm/yy (example: 12 Aug 96)
5. DATE OF BIRTH. Enter DOB of sponsor. List by dd/mmm/yyyy (example: 11 Oct 1962).
6. RANK. List rank of sponsor (not pay grade). (example: Army 0-4 should be MAJ).
7. TELEPHONE NUMBER. Sponsor's work phone and home phone.
8. DUTY ADDRESS. Please list Unit, Office Symbol, Installation, APO/FPO and Zip Code.
9. MAILING ADDRESS. This is your home mailing address. Include PSC, Box Number, APO/FPO and Zip Code.
10. PREFERRED PRIMARY CARE SITE. If you reside in an area which has more than one hospital or clinic in the area from which you choose to receive your medical care, you should indicate in this block, the preferred site you would like to receive that care. Example: In the Kaiserslautern, Germany area you can select from Landstuhl, Kleber, Ramstein, or Sembach Clinics to receive your primary care. Simply identify your preference in this block.
11. BRANCH OF SERVICE. Circle the appropriate selection.
12. SPONSOR STATUS. Circle the appropriate selection.
13. SPONSOR MEDICAL CONDITIONS. If the sponsor has any special medical conditions (allergies, reactions to certain medications, diabetes, etc.), they should be briefly noted in this section. If more room is needed, write on the back of application.
14. FAMILY MEMBER NAME. List each family member (last name, first name, middle initial) who has accompanied the sponsor to Europe and will reside in Europe with the sponsor.
15. FAMILY MEMBER SOCIAL SECURITY NUMBER. Please list the Social Security Numbers for each family member. If the family member has not yet been issued a SSN, write that in this section. If you do not know the number, please write that in the appropriate block.
16. SEX. Gender of family member.
17. DATE OF BIRTH. List the date of birth for each family member.
18. PREFERRED PRIMARY CARE SITE. Please see instructions for Block 10.
19. FAMILY MEMBER MEDICAL CONDITIONS. See instructions for Block 13. Please ensure that you have identified the appropriate medical conditions for each family member. If one of the family members is served by the Exceptional Family Member Program (EFMP), please indicate this as well.
20. ENROLLMENT AUTHORIZATION. Please indicate your choice by checking the appropriate box.
21. SIGNATURE. Either adult beneficiary must sign and date the form. The signature of the sponsor or the sponsor's spouse is required.

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10, USC, Sec. 1095 and 1099; EO 9397
PRINCIPAL PURPOSE(S):	Information will be used to enroll the beneficiary(ies) in TRICARE Europe Prime, and to assign Primary Care Managers (PCMs) to each enrollee. Information will also be used by military treatment facility (MTF) staff and TRICARE contractors to determine eligibility for care and payment of claims.
ROUTINE USE(S):	The information on this form will be released to the MTF staff, TRICARE contractors, and providers of health care.
DISCLOSURE:	